

**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

In re Flint Water Cases.
_____ /

Judith E. Levy
United States District Judge
Case Number: 5:16-cv-10444

This Order Relates To:

ALL CASES
_____ /

CASE MANAGEMENT ORDER

This Case Management Order (“CMO”) shall apply to all plaintiffs with cases pending as of November 10, 2021 and to all new plaintiffs filing cases after that date (“Plaintiff” or “Plaintiffs”), whose claims are related to Flint water and not released by the Settlement Agreement in this action entered into on November 16, 2020 (“Settlement Agreement”). Pursuant to Federal Rule of Civil Procedure (“FRCP”) 42, all such new cases filed in the Eastern District of Michigan shall be assigned to the *In re Flint Water Cases* Litigation pending before this Court and shall be subject to the terms of this CMO.

1. Filing of Amended Complaints. Each Plaintiff with an existing case as of November 10, 2021 shall file and serve on Defendants within ninety (90) days of that date an Amended Complaint satisfying the requirements of the FRCP and this CMO, if that Plaintiff’s case is not dismissed with prejudice prior to this deadline pursuant to the Settlement Agreement. Plaintiff’s counsel shall comply with Rule 11 of the FRCP when filing any such Amended Complaint.

2. Content of Complaints. A Plaintiff who files a new Complaint, or who amends their Complaint pursuant to Section 1 of this CMO, shall include in their new Complaint or Amended Complaint, in addition to the information required pursuant to the FRCP, the detailed information identified in Section 5 (a), and (d) through (f) below. A Plaintiff shall also identify the particular Defendant or Defendants that Plaintiff alleges are liable for her, his, or its alleged injury or damage connected to Flint water, and the particular factual and legal basis for such alleged liability specific to each particular Defendant that Plaintiff seeks to hold liable.

3. Completion of Fact Sheet. Each Plaintiff that files a new Complaint or an Amended Complaint shall subsequently serve upon the Defendants within thirty (30) days of that filing a completed copy of the Fact Sheet, attached hereto as Exhibit A, and a verified statement under oath setting forth the exact nature of the exposure to Flint water during the relevant time frames.

4. Requirement to Serve Case-Specific Expert Reports. Each Plaintiff alleging injury or damage (including each personal representative of an estate of any deceased person, or other proper representative for a minor or legally incapacitated individual) shall serve a case-specific expert report or reports executed by a qualified expert, under oath and subject to the penalties of perjury, stating that there: is a causal relationship between the individual Plaintiff's claimed injury or damage and exposure to Flint water and the good faith basis for that opinion; and quantifying those claimed damages sustained by the Plaintiff, with specific calculations and evidence for each component of such damages (a "Case-Specific Expert Report"). Each

Plaintiff shall serve a Case-Specific Expert Report on Defendants within sixty (60) days of filing a new Complaint or Amended Complaint in accordance with the FRCP and the requirements of this CMO.

5. Contents of Case-Specific Expert Report. Each Case-Specific Expert Report shall, in addition to any other information required under the Federal Rules of Civil Procedure or the Federal Rules of Evidence, include the following information from a qualified expert in the relevant field:

a. *Plaintiff's Information.* The Plaintiff's name and date of birth;

b. *Expert's Information.* The name, professional address, and curriculum vitae of the physician or expert, including a list of all publications authored by the expert within the preceding ten (10) years, and the foundation for the expert's opinion in relation to his or her professional experience;

c. *Plaintiff's Records.* All records reviewed by the expert in preparation of the Case-Specific Expert Report;

d. *Exposure Dates.* The dates during which the Plaintiff alleges that he, she, it, or the Plaintiff's property was exposed to contaminated Flint water and copies of documents relied upon, if any, as evidence of such alleged exposure;

e. *Exposure Locations.* The location(s) at which the Plaintiff alleges that he, she, it, or the Plaintiff's property was exposed to contaminated Flint water and copies of documents relied upon, if any, as evidence of such alleged exposure.

f. *Plaintiff's Injury or Damage.* Whether the Plaintiff's records reviewed by the expert indicate that the Plaintiff suffered an injury or damage causally related to alleged exposure to contaminated Flint water and, if so: (i) the nature of the alleged injury or damage; (ii) the basis for the expert's opinion that the injury or damage was causally related to exposure to contaminated Flint water; and (iii) references to the particular record(s) relied upon as evidence of such alleged injury or damage;

g. *Opinion Regarding Causation Sworn to by Expert.* An opinion that there is in fact a causal relationship between the individual Plaintiff's claimed injury or damage and his, her, or its exposure or the exposure of Plaintiff's property to contaminated Flint water, prepared and sworn/affirmed to by a physician or other expert and subject to the penalties of perjury.

h. *Opinion Regarding Damages Sworn to by Expert.* An opinion quantifying the damages sustained by the Plaintiff due to his, her, or its exposure to contaminated Flint water, with specific calculations and evidence for each component of such damages, prepared and sworn/affirmed to by an expert and subject to the penalties of perjury.

6. Responding to Complaints. The time for Defendants to file a response to a new Complaint or Amended Complaint shall not begin to run until after the receipt by counsel for the Defendants of the Case-Specific Expert Report required pursuant to this CMO (subject to the non-compliance and opportunity to cure

provisions in Section 11 below), and after the claims process is concluded as described in Section 10 below, whichever is later.

7. Preservation Notice Requirement. Within thirty (30) days of filing a new Complaint or Amended Complaint, Plaintiffs shall notify the following individuals or entities, if applicable, by registered mail (with return receipt) (each a “Notice”) that the individual or entity may have records relevant to the Plaintiff’s claim in these cases and that any records relating to the Plaintiff must be preserved as directed herein, pending collection by the Plaintiff or Defendant:

- a. All pharmacies that dispensed any medications to the Plaintiff for the period from three years prior to the date of the first diagnosis of the alleged injury to the present;
- b. For the period of three years prior to the date of the first diagnosis of the alleged injury to the present:
 - i. Plaintiff’s primary care physician(s);
 - ii. Any healthcare provider(s) who treated Plaintiff for the alleged injury; and
 - iii. Any hospital(s) that treated Plaintiff for any reason.

A copy of this CMO shall be attached to the Notice sent pursuant to this Section and all copies of the Notice shall be preserved by Plaintiff for so long as the Claim remains pending in this proceeding.

8. List of Notices. Plaintiffs shall serve on Defendants within sixty (60) days of filing their Complaint or Amended Complaint a statement listing the names

and addresses of all individuals or entities to which Notices were sent, along with copies of the Notices and a signed certification that the Notices were sent as required by this CMO.

9. Discovery Requirements. Within ninety (90) days of filing a new Complaint or an Amended Complaint, if applicable, Plaintiffs shall produce to Defendants the following documents and/or information:

- a. All pharmacy records regarding the dispensing of medications to the Plaintiff for the period from three years prior to the date of the first diagnosis of the alleged injury to the present;
- b. All medical records for the period of three years prior to the date of the first diagnosis of the alleged injury to the present for:
 - i. Plaintiff's primary care physician(s);
 - ii. Any hospital(s) that treated Plaintiff for any reason, and
 - iii. Any healthcare provider(s) who treated Plaintiff for the alleged injury.
- c. All results for any blood lead level tests performed on the Plaintiff;
- d. All results for any water tests performed at a property where Plaintiff is alleging exposure to contaminated Flint water that caused injury or damage, and all evidence of such property being served by lead or galvanized steel service lines.
- e. All academic records for any person who was a minor when allegedly

exposed to contaminated Flint water.

- f. All documents and information quantifying the damages sustained by the Plaintiff due to his, her, or its exposure to contaminated Flint water, with specific calculations and evidence for each component of such damages.
- g. If any of the documents described in subparagraphs (a) through (f) do not exist, Plaintiff shall serve Defendants with a notice stating that fact and the reason, if known, why they do not exist.

10. Claims Process Required with Accept/Reject Decision. Each Plaintiff who files a new Complaint or an Amended Complaint shall submit within thirty (30) days of that filing a completed claims form to the settlement claims administrator, as if such Plaintiff was a Claimant participating in the settlement in accordance with the Settlement Agreement. If the claims administrator requires additional information in order to fully process the claim, such Plaintiff will provide that information to the best of their abilities. Such Plaintiff must then accept or reject the amount of the award resulting from such claim after it has been administered through the claims process described in the Settlement Agreement. Such Plaintiff must accept or reject the amount of the award within 30 days of being notified of the amount, after all administrative appeals, if any. If such Plaintiff accepts the proposed award, the award shall be finalized and paid subject to the terms of the Settlement Agreement, and the Plaintiff's case dismissed with prejudice by the Court. If such Plaintiff rejects the proposed award, the Plaintiff may then and only then proceed to

litigate such Plaintiff's case in Court. The claims administrator is Archer Systems, LLC and the contact information is the following:

Archer Systems, LLC
Re: Flint Water Settlement
1775 St. James Place, Suite 200
Houston, TX 77056

E-mail to send information to is: flintwater@archersystems.com

Dedicated Phone Number is: (800) 493-1754

11. Dismissal of Plaintiffs Who Fail to Comply With This Order.

a. *Notice of Non-Compliance and Opportunity to Cure.* If any Plaintiff fails to comply with any provision of this Order, Defendants shall provide Plaintiff written notice of such non-compliance ("Notice of Non-Compliance") specifying the non-compliance. Upon receipt of a Notice of Non-Compliance, Plaintiff shall have sixty (60) days to cure her, his, or its non-compliance specified in the Notice of Non-Compliance. During the period wherein non-compliance has not yet been cured, all litigation deadlines applicable to Defendants, including without limitation deadlines for discovery or to file and serve a pleading or motion responsive to Plaintiff's new Complaint or Amended Complaint, shall be held in abeyance.

b. *Failure to Cure.* If, after the passage of sixty (60) days of service of a Notice of Non-Compliance, a Plaintiff fails to cure her, his, or its non-compliance, upon application by the Defendants, the Plaintiff's claims, as well as any derivative claim(s), will be dismissed with prejudice pursuant to FRCP 41(b) as against the Listed Defendants only.

c. Extensions of Time. The Court, on motion and for good cause shown, may order an extension of the time to comply with this Order.

12. Sanctions. Any Plaintiff or counsel for that Plaintiff who submits false or misleading information, or otherwise attempts to satisfy the documentation requirements of this Order through any form of deception, dishonesty or fraud, may be subject to appropriate sanctions (including monetary sanctions and costs) and dismissal with prejudice pursuant to Federal rule of Civil Procedure 37.

IT IS SO ORDERED.

Dated: December 22, 2021
Ann Arbor, Michigan

s/Judith E. Levy
JUDITH E. LEVY
United States District Judge

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was served upon counsel of record and any unrepresented parties via the Court's ECF System to their respective email or first-class U.S. mail addresses disclosed on the Notice of Electronic Filing on December 22, 2021.

s/William Barkholz
WILLIAM BARKHOLZ
Case Manager

EXHIBIT A TO CASE MANAGEMENT ORDER

PLAINTIFF'S FACT SHEET

I. INSTRUCTIONS AND DEFINITIONS

Please fill out a separate Fact Sheet for each person on whose behalf a claim is being made. The purpose of this Fact Sheet is to obtain accurate information about basic facts that are relevant to claims arising out of the distribution of water from the City of Flint Water Supply during and after April of 2014. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. Information in the Fact Sheet may be used as evidence at the trial in this case. If you cannot provide all of the details requested, please provide as much information as you can. Please do not leave any blank answers. Where appropriate, please indicated “none,” “do not know,” or “not applicable.” In addition, you must supplement your responses if you learn later that they are incomplete or incorrect in any material respect.

If you are making a claim for injuries or losses you claim that you yourself have suffered as a result of exposure to water during or after April of 2014, you must complete a Fact Sheet for yourself. If you are making a claim on behalf of one or more children for injuries or losses you claim the children suffered as a result of exposure to water during or after April of 2014, then you must complete a separate Fact Sheet for each child on whose behalf you are making a claim. If you are making a claim as the guardian or other representative of a person who is too disabled to make a claim on his or her own behalf, or if you are making a claim as the executor, administrator, or other representative of the estate of a person who has died, then you must complete a separate Fact Sheet for each such person. If you are completing the Fact Sheet for someone other than yourself, please answer as completely as you can for that person. If you are completing a Fact Sheet on behalf of a business, please fill out Section II. 3, and complete the remainder of the form as to the business.

It may be that you do not have all the information you would need to give complete answers to some of the questions in this Fact Sheet. If that is the case, you are still required to provide all of the information you do have, even though it is not complete. It is also important to understand that, in completing the Fact Sheet, you may not rely just on your memory if you have in your possession, or easily available to you, documents, reports, e-mails, text messages, voicemails, or other written or electronic information that you can consult in order to obtain the requested information. Your answers to the questions in the Fact Sheet must be as complete and accurate as you can make them, even if answering requires you to devote time and effort to finding and reviewing written and electronic information

available to you. Also, please remember that you cannot object to the questions, but must provide the information requested to the best of your ability.

Please note that information deemed to be confidential by a protective order agreed or to be agreed upon between Plaintiff and Defendant counsel and entered in this case (including your social security number) will be treated confidentially by the parties pursuant to the terms of the protective order.

Completed Fact Sheets should be forwarded to your attorney. Please consult with your attorney as to the deadline for completion of the Fact Sheet.

In completing the Fact Sheet, please use the following definitions:

“Health care provider” means any doctor, physician’s assistant, nurse practitioner, or other individual health care professional regardless of title; hospital, clinic, urgent care, ready care, community health or medical center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice; and any pharmacy, x-ray department, radiology department, laboratory, physical therapist, occupational therapist, dentist, audiologist, ophthalmologist, psychiatrist, psychologist, or any other persons or entities involved in the care or treatment of you, or of the person for whom you are completing the Fact Sheet.

“Plumbing” means any service lines, piping, or other fixtures or appliances through which water from the City of Flint Water Supply is or was conveyed from the municipal water main to the water faucets, showers, toilets, etc. within a residence or other building.

II. QUESTIONNAIRE

1. CASE INFORMATION [to be completed by your attorney]

a. CLAIMANT/PLAINTIFF NAME:

b. CASE NAME:

d. CASE NUMBER:

e. LAW FIRM:

f. TYPE OF ALLEGED INJURY/INJURIES OR DAMAGE (fill in all that apply to the plaintiff to whom this Fact Sheet applies):

_____CHILD PERSONAL INJURY

_____ADULT PERSONAL INJURY

_____PROPERTY DAMAGE/LOSS

_____REIMBURSEMENT FOR WATER BILLS PAID

_____DIMINUTION IN VALUE OF REAL ESTATE

_____ OTHER: _____

2. **INFORMATION ABOUT PERSON COMPLETING THIS FACT SHEET**

a. Full Name:

b. Previous Names:

c. Date of Birth:

d. Place of Birth:

e. Social Security Number:

f. Male or Female: ___Male ___Female

g. Present Residential Address:

Street Address (including any apartment or
unit number)

City/ Town State Zip Code

h. Dates at this Address:

i. Other residential addresses since April 1, 2014 and dates at each (add sheets if necessary):

- j. Other residential addresses between January 1, 2004 and April 1, 2014, and dates as each (add sheets if necessary):

3. INFORMATION ABOUT BUSINESS COMPLETING THIS FACT SHEET

a. Name of Business:

b. Taxpayer ID No.:

c. Business Address:

d. Dates at this Address:

From

To

e. Prior Addresses since
April 2014:

Street Address (including any apartment or unit number)

City/ Town

State

Zip Code

f. Dates at each Address:

From

To

4. REPRESENTATION OF ANOTHER PERSON

If you are completing this Fact Sheet for yourself or for your business, please skip to Section 5.

If you are completing this Fact Sheet as a representative of someone else (i.e., on behalf of the estate of a deceased person, an incapacitated person, or a minor), please complete the following for them:

- a. Describe the capacity in which you are representing the individual or estate (e.g., parent, guardian, next friend, personal representative of estate):

- b. If you were appointed as a representative by a court, state the following or attach a copy of the order appointing you:

The court which appointed you:

The date of your appointment:

- c. What is your relationship to the individual you represent?

- d. If you represent a deceased person's estate, please state:

The date of the decedent's death:

The address(es) at which the decedent lived from April 2014 to the date of death:

- e. If you are making a claim regarding the death of a family member, please identify any and all family members, beneficiaries, heirs or next of kin, including their relationship to the decedent:

- f. If you are completing this Fact Sheet as a representative, please provide the following information regarding the person for whom you are filling out the Fact Sheet:

i. Full Name:

ii. Previous Names:

iii. Date of Birth:

iv. Place of Birth:

v. Social Security Number:

vi. Male or Female:___Male ____Female

vii. Present Residential Address:

Street Address (including any
apartment or unit number)

City/ Town State Zip
Code

viii. Dates at this Address:

From To

ix. Separately List Prior Addresses since
April 2014:

Street Address (including any apartment or
unit number)

City/ Town State Zip Code

x. Dates at each Address:

From To

5. **INFORMATION REGARDING WATER TESTING**

All plaintiffs should complete this section.

- a. For all addresses listed above where your residence (or, if you are filling this out on behalf of another person, that other person) or your business was located during or after April of 2014, please provide the following information:

Address:

Was this property serviced before January 1, 2021, by water service lines that were made entirely or partially from lead?

YES _____ NO _____ I DO NOT KNOW _____

Did this property have any lead plumbing within the residence or property (that is, plumbing through which water from the outside traveled to faucets, showers, bathtubs, dishwashers, water heaters, washing machines, etc.) before January 1, 2021?

YES _____ NO _____ I DO NOT KNOW _____

Were water samples collected from this address tested for lead, other metals, chemicals, or other contaminants since April 25, 2014?

YES _____ NO _____ I DO NOT KNOW _____

If you answered yes to the preceding question, state to the best of your knowledge the date(s) when water lead testing was done, the person requesting the sampling/testing, the person taking the sample, the facility or laboratory which performed the testing and the test results:

Dates water sample was collected and tested:

Name of person requesting sampling/testing:

Name of person or company who collected sample:

Facility/Lab or agency which performed test:

Results:

- b. **Please attach copies of any water lead test results in your possession or control.**

6. **CHILD PERSONAL INJURY CLAIMS**

Complete this section only if you allege personal injuries on behalf of a minor child. In this section, "you" refers to the minor child.

- a. Do you claim that you have been injured as a result of exposure to lead in water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- b. If you answered yes, state to the best of your knowledge each date on which you have undergone testing for lead levels, identify who took the sample to be tested, type of testing (e.g. blood lead, bone mineral study, hair analysis, urinalysis, tooth analysis) and provide the reported results of the testing.

Date tested:

Type of Test (select one): ____Intravenous ____Finger Prick ____Other

Results:

Facility/Lab:

If additional testing was done, please attach additional information.

- c. **Please attach copies of any lead test results in your possession or control.**
- d. In addition, if you have been told at any time by any health care provider that you have been injured as a result of lead in water distributed by the City of Flint Water Supply, please identify the health care provider, state what you were told to the best of your ability and provide the date you were told this. (Attach additional sheets as necessary, and attach copies of any statements by a health care provider made in writing). If no health care provider has told you or the child that the child has been injured by lead in water distributed by the City of Flint, state "None."

- e. Do you claim that you have suffered from Legionnaire's Disease (Legionella) as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- f. If you have been told by any health care provider at any time that you have suffered from Legionnaire's Disease (Legionella) at any time, please identify the health care provider(s), state exactly what you were told to the best of your ability, and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the child that the child has suffered from Legionnaire's Disease or legionella infection as a result of exposure to water distributed by the City of Flint, state "None."

- g. Do you claim you have suffered from any other illness as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES: _____ NO: _____

- h. If you answered yes to the preceding question, please state what illness(es) you allege you have suffered as a result of exposure to water distributed by the City of Flint Water Supply.

- i. If you answered yes to section 6. g., please state whether you have been told by any health care provider that you have suffered from an illness which you believe was caused by exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014. If so, please identify the health care provider(s), state what you were told to the best of your ability and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the child that the child has suffered from any one or more of the diseases you identified in answer to the subpart g as a result of exposure to water distributed by the City of Flint, state with respect to that illness "None."

j. **Please identify each of your health care providers (including doctors, nurse practitioners, dentists, and other health care professionals, institutions, hospitals, clinics, and urgent care facilities) from January 1, 2004 to the present and attach signed and dated authorizations for release of medical records directed to each of these health care providers.**

k. Are you currently enrolled in school? ____Yes ____No

l. What is the highest level of education that you have completed:

m. Please list any schools you have attended (elementary, middle, junior high or high schools, junior colleges, vocational schools, universities, institutes or seminaries):

i. _____
Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

ii. _____
Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

iii.

Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

Please attach any additional information, including copies of any degrees or certificates.

- n. **Attach signed and dated authorizations for release of education and academic records directed to each school attended using the attached form.**
- o. Have you applied for or received social security disability benefits at any time since April 25, 2014?
- YES: _____ NO: _____
- p. If so, state the date when you submitted an application for social security disability benefits and the dates, if any, for which such benefits were received:

Date Application Was Submitted

Dates For Which Benefits Received

- q. **If applicable, please attach a signed and dated authorization for release of social security disability records using the attached form.**

- r. Are you claiming lost wages as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- s. If yes, please describe the lost wages suffered by you, and identify each employer, state the relevant time period and estimate of the amount of your lost wages?

- t. **If applicable, please attach signed and dated authorizations for the release of employment records directed to each employer as to whom you claim lost wages.**

- u. Please provide for each of your health insurers since January 1, 2004 (attach additional sheets if necessary):

i. Name of Insurer

ii. Dates You Had Coverage with this Insurer

iii. Name of Insurer

iv. Dates You Had Coverage with this Insurer

- v. **Please attach signed and dated authorizations for the release of records from all health insurers identified in your response to question 6. u. using the attached form.**

7. ADULT PERSONAL INJURY CLAIMS

Complete this section only if you have filed (or are representing an adult who has filed) a claim for personal injuries. In this section, "you" means either you or an adult claimant whom you represent.

- a. Do you claim that you have been injured as a result of exposure to lead in water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- b. If you answered yes, state to the best of your knowledge each date on which you have undergone lead level testing (e.g. blood lead testing, bone mineral study, hair analysis, urinalysis, tooth analysis), identify who took the sample to be tested and provide the reported results of the testing.

Date tested:

Type of Test (select one): ____Intravenous ____Finger Prick
____Other

Results:

Facility/Lab:

If additional testing was done, please attach additional information.

- c. **Please attach copies of any lead test results in your possession or control.**
- d. In addition, if you have been told at any time by any health care provider that you have been injured as a result of lead in water distributed by the City of Flint Water Supply, please identify the health care provider, state exactly what you were told to the best of your ability and provide the date you were told this. (Attach additional sheets as necessary, and attach copies of any statements by a health care provider made in writing). If no health care provider has told you that you have been injured by lead in water distributed by the City of Flint, state "None."

- e. Do you claim that you have suffered from Legionnaire's Disease (Legionella) as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- f. If you have been told by any health care provider at any time that you have suffered from Legionnaire's Disease (Legionella) at any time, please identify the health care provider(s), state exactly what

you were told to the best of your ability, and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the adult on whose behalf you are completing this form that you or they suffered from Legionnaire's Disease or legionella infection as a result of exposure to water distributed by the City of Flint, state "None."

- g. Do you claim you have suffered from any other illness as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES: _____ NO: _____

- h. If you answered yes to the preceding question, please state what illness you allege you have suffered as a result of exposure to water distributed by the City of Flint Water Supply.

- i. If you answered yes to section 7. g., please state whether you have been told by any health care provider that you have suffered from an illness which you believe was caused by exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014. If so, please identify the health care provider(s), state exactly what you were told to the best of your ability and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the adult on whose behalf you are completing this form that you or they suffered from any one or more of the illnesses you identified in answer to section 7.g. as a result of exposure to water distributed by the City of Flint, state "None."

- j. **Please identify each of your health care providers from January 1, 2004 to the present and attach signed and dated authorizations for release of medical records directed to each of these health care providers.**

- k. Are you currently enrolled in school? ____Yes ____No

- l. What is the highest level of education that you have completed?

- m. Please list any schools you have attended (elementary, middle, junior high or high schools, junior colleges, vocational schools, universities, institutes or seminaries):

i. _____
Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

ii. _____

Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

iii. _____

Name of school

Address

Years of Attendance

Degree or Certificate (if any) Received

Please attach any additional information, including copies of any degrees or certificates.

- n. **Attach signed and dated authorizations for release of education records directed to each school attended using the attached form.**

- o. Have you applied for or received social security disability benefits at any time since April 25, 2014?

YES: _____ NO: _____

- p. If so, state the date when you submitted an application for social security disability benefits and the dates, if any, for which such benefits were received:

Date Application Was Submitted

Dates for Which Benefits Received

- q. **If applicable, please attach a signed and dated authorization for release of social security disability records using the attached form.**
- r. Are you claiming lost wages as a result of exposure to water distributed by the City of Flint Water Supply at any time since April 25, 2014?

YES _____ NO _____

- s. If yes, please describe the lost wages suffered by you, and identify each employer, state the relevant time period and estimate of the amount of your lost wages?

Names and Addresses of Employers:

Dates of Employment at each Employer:

- t. **If applicable, please attach signed and dated authorizations for the release of employment records directed to each employer as to whom you claim lost wages.**
- u. Please provide for each of your health insurers since January 1, 2004 (attach additional sheets if necessary):

- i. Name of Insurer
- ii. Dates You Had Coverage with this Insurer
- iii. Name of Insurer
- iv. Dates You Had Coverage with this Insurer
- v. **Please attach signed and dated authorizations for the release of records from all health insurers identified in your response to question 7. u. using the attached form.**

8. **PROPERTY DAMAGE/LOSS CLAIMS**

Complete this section only if: (1) you own or lease or have owned or leased a property or residence since April 25, 2014, or (2) the person on whose behalf you are executing this fact sheet owns or leases or has owned or leased a property or residence since April 25, 2014; and (3) you allege on behalf of yourself or another person damage to real estate, personal property, or associated plumbing as a result of the distribution of water from the City of Flint Water Supply to that property or residence since April 25, 2014, and/or a related loss of income or value.

- a. Please provide the address of each piece of real estate or a description of the personal property where you claim you have suffered such damage, state the dates of ownership of the property by you, and describe the nature of the damage:
- b. State, with respect to each piece of real or personal property you have described in answer to subpart a., the date on which you or the person on whose behalf you are completing this Fact Sheet purchased or otherwise acquired an ownership interest in the property:
- c. State, with respect to each piece of real or personal property you have described in answer to subpart a., the names and addresses of all other persons who had an ownership interest in the property at the time it was damaged:
- d. Do you or the person on whose behalf you are completing this Fact Sheet claim to have incurred expense to repair or replace damage

caused by contaminated City of Flint water to real estate or personal property described in answer to subsection a?

YES _____ NO _____

- e. If you answered Yes to subpart d., state with respect to each piece of real estate or personal property that was damaged by contaminated City of Flint water the amount you or an insurer on your behalf paid to repair or replace the property:

- f. Do you claim to have suffered a loss of rental or other income as a result of the distribution of water from the City of Flint Water Supply since April 25, 2014?

YES _____ NO _____

- g. If you answered yes to the preceding question, state the address of each piece of real estate for which you claim to have lost rental or other income since April 25, 2014, and the net rental income produced by the property for each year between January 1, 2012 and January 1, 2021:

9. CLAIMS FOR DIMINUTION IN VALUE OF REAL ESTATE

- a. Do you claim to have suffered a reduction or diminution of property value as a result of the distribution of water from the City of Flint Water Supply since April 25, 2014?

YES _____ NO _____

- b. If you answered yes to the preceding question, state the address of each piece of real estate for which you claim to have suffered a reduction or loss of property value since April 25, 2014, the amount of such reduction, and the ownership interests since April 25, 2014 (include the names and addresses of any other co-owners):

- c. Do you claim to have incurred out of pocket costs (such as costs to repair or replace damaged property) as a result of the distribution of water from the City of Flint Water Supply since April 25, 2014?

YES _____ NO _____

- d. If you answered yes to the preceding question, state the address of each piece of real estate for which you claim to have incurred out of pocket costs since April 25, 2014, and state with particularity what those costs are:

10. WATER BILL CLAIMS

Please complete this section only if you allege on behalf of yourself or another person on whose behalf you are completing this Fact Sheet that you or they are entitled to reimbursement and/or other damages relating to the payment of water bills for water from the City of Flint Water Supply since April 25, 2014.

- a. Please state the address of each property for which you seek reimbursement of water bills, and the total amount paid to the City of Flint from April 25, 2014 to January 1, 2021.
- b. Is the account referred to in 10a in your name? Yes _____ No _____
- c. If not, please identify the person(s) in whose name the account was in with the corresponding dates, since April 25, 2014:
- d. Did you notify the City of Flint of concerns regarding the quality of the water provided to you? If so, please state when the notice occurred, who provided the notice, whether the notice was oral or written and provide any documents in your possession or control documenting such notice.

- e. Have you attempted to challenge or negotiate in any way your water bills with the City of Flint's Water Department? If so, please describe what you have done to contest your water bills with the City.
- f. Have you, or the person on whose behalf you are completing this Fact Sheet, received any water credits or discounts from the City of Flint or the State of Michigan on water bills since April 25, 2014?
YES _____ NO _____ I DON'T KNOW AND CAN'T FIND OUT _____
- g. If you answered yes to subsection f., state the total dollar amount of the credits or discounts:

I understand that the information I have provided in this Plaintiff Fact Sheet will be used in relation to the lawsuit that has been filed on my behalf, or on behalf of the person for whom I have completed this Fact Sheet.

I declare under penalty of perjury under the laws of the State of Michigan and the United States of America that the foregoing information is true and correct to the best of my knowledge and belief.

Date: _____

Name of Plaintiff

Signature of Plaintiff

Or

Date: _____

Name of Representative

Signature of Representative

CONSENT TO RELEASE OF ACADEMIC RECORDS

To: _____
(Name of academic institution or department that will be releasing the records)

This request for information of all educational records, is made with respect to the following student, who is referred to as "*Student*" in this Consent Form:

Name of Student: _____

Date of Birth: _____

Social Security No.: _____

Student Identification Number: _____

Address: _____

Please provide information from the educational records of the Student to the following person:

[Name and address of person to whom the educational records will be released, and, if appropriate, the relationship to the student (i.e., "parents" or "attorney"). This person is referred to as "*Recipient*" in this Consent Form.

The information to be released under this consent shall consist of ALL RECORDS.

The information is to be released for the purposes of a lawsuit.

I, Student, consent to release of the documents and information identified above to the Recipient, including the release of any and all information that is protected by the Federal Family Education Rights and Privacy Act of 1974, 20 U.S.C. § 1232g *et seq.* ("FERPA"). I waive any written notice of the release of such records that may be required by federal or state law. A PHOTOCOPY OR FACSIMILE OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED. I understand that this authorization will be effective until I revoke it in writing and deliver the revocation to the academic institution or department first listed above.

Dated: _____

Signature: _____

Student: [name] _____

CONSENT TO RELEASE OF EMPLOYMENT RECORDS

To: _____

[Name and address of employer who will be releasing the records]. This entity/person is referred to as "Employer" in this Consent Form.

This request for information from the employment records, is made with respect to the following employee, who is referred to as "*Employee*" in this Consent Form:

Name of Employee: _____

Date of Birth: _____

Social Security No.: _____

Address: _____

Please provide information from the employment records of the Employee to the following person:

[Name and address of person to whom the employment records will be released]. This person is referred to as "*Recipient*" in this Consent Form.

I, Employee, consent to release of my complete personnel file and all of my employment records to the Recipient, including all disciplinary records, financial records, and medical records. I waive any written notice of the release of such records that may be required by federal or state law. I authorize Employer to release all of this information without liability for damage resulting from such release. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, to the extent applicable, no longer be protected by HIPAA. I understand that this authorization will be effective until I revoke it in writing and deliver the revocation to Employer at the address listed above.

A PHOTOCOPY OR FACSIMILE OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED.

Dated: _____

Signature: _____

Employee: [name] _____

AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC RECORDS

Name of Medical Care Provider/Hospital:

Name of Patient:

Date of Birth:

Social Security No.:

I, _____, hereby authorize the Custodian of Records of the above referenced entity to release protected health information, including any and all information which may be requested regarding my past or present physical, emotional, or psychological condition, injuries, or disease, regarding which I have consulted you or received your services, including, but not limited to, the nature of any impairment, history, contributing factors, complications, prescriptions, x-rays, testing, notes, hospital records, medical or psychiatric records, behavioral medicine services records, including communications made by me to a social worker or psychologist, unredacted progress notes, period of disability, subjective symptoms, prognosis, statement of charges, alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, any information regarding communicable diseases and infections as defined by MCL 333.5131, including venereal diseases, tuberculosis, HIV, AIDS, and ARC, and any further information which may be available to you. This authorization is made pursuant to HIPAA.

Disclosure is made to:

ATTORNEYS: _____

The purpose and need for disclosure is for all purposes allowable under the law. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

This authorization is for copying purposes only, and does not authorize *ex parte* communication.

This authorization is valid for the duration of the lawsuit,
_____, _____ Court Case No.
_____.

I may revoke this authorization in writing in accordance with the Privacy Notice of the medical care provider or hospital identified above.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED.

Dated: _____

[Patient Name]

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

- 1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
- 2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
- 3.To comply with Federal laws requiring the disclosure of the information from our records; and,
- 4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

*My Full Name

*My Date of Birth
(MM/DD/YYYY)

*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

*I want this information released because:

We may charge a fee to release information for non-program purposes.

*Please release the following information selected from the list below:
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number

2. ☐ Current monthly Social Security benefit amount

3. ☐ Current monthly Supplemental Security Income payment amount

4. ☐ My benefit or payment amounts from date _____ to date _____

5. ☐ My Medicare entitlement from date _____ to date _____

6. ☐ Medical records from my claims folder(s) from date _____ to date _____
If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

7. ☐ Complete medical records from my claims folder(s)

8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

*Signature:

*Date:

**Address:

**Daytime Phone:

Relationship (if not the subject of the record):

**Daytime Phone:

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness	2. Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)